13) the criteria used to identify specialty hospital peer groups; and

14) the criteria used to establish the level of burn care.

d. Burden of Proof

The hospital shall bear the burden of proof in establishing the facts and circumstances necessary to support a rate adjustment. Any costs that the provider cites as a basis for relief under this provision must be calculable and auditable.

e. Information to be Provided

All requests for qualifying loss review shall specify the following:

1) the nature of the adjustment sought;
2) the amount of the adjustment sought;
3) the reasons or factors that the hospital believes justify an adjustment; and
4) an analysis demonstrating the extent to which the hospital is incurring or expects to incur a qualifying loss. However, such analysis is not required if the request is limited to a claim that:
   a) the rate-setting methodology or criteria for classifying hospitals or hospital claims were incorrectly applied;
   b) incorrect or incomplete data or erroneous calculations were used in establishment of the hospital rates; or
   c) the hospital has incurred additional costs because of a catastrophe.

f. Factors Considered

In determining whether to award additional reimbursement to a hospital that has made the showing required, the following factors shall be considered:

1) whether unreimbursed costs are generated by factors generally not shared by other hospitals in the hospital's peer group. Such factors may include, but are not limited to, extraordinary circumstances

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beyond the control of the hospital, and improvements required to comply with licensing or accrediting standards. Where it appears from the evidence presented that the hospital's costs are controllable through good management practices or cost containment measure, the request for rate adjustment may be denied.

2) financial ratio data indicative of the hospital's performance quality in particular areas of hospital operation. The hospital may be required to provide additional data.

3) whether every reasonable action to contain costs on a hospital-wide basis has been taken. The hospital may be required to provide audited cost data or other quantitative data (including but not limited to) occupancy statistics, average hourly wages paid, nursing salaries per adjusted patient day, average length of stay, cost per ancillary procedure, average cost per meal served, average cost per pound of laundry, average cost per pharmacy prescription, housekeeping costs per square foot, medical records costs per admission, full-time equivalent employees per occupied bed, age of receivables, bad debt percentage, inventory turnover rate, and information about actions that the hospital has taken to contain costs.

g. Determination to Award Relief

Additional reimbursement shall be awarded to a hospital that demonstrates to the Department by clear and convincing evidence that:

1) the hospital demonstrated a qualifying loss; and
2) the hospital's current prospective rate jeopardized the hospital's long-term financial viability; and
3) the Medicaid population served by the hospital has no reasonable access to other inpatient hospitals for the services that the hospital provides and that the hospital contends are under-reimbursed.

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h. Relief Awarded

Notification of decision regarding qualifying loss review shall be provided in writing. Should the decision be to award relief, relief consists of making appropriate adjustments so as to correctly apply the rate-setting methodology, or to correct calculations, data errors, or omissions. A hospital's corrected rate component shall not exceed the lesser of its recalculated cost for that component or 150% of the provider's peer group rate for that component.

If subsequent discovery reveals that the provider was not eligible for qualifying loss relief, any relief awarded under this qualifying loss process shall be recouped.

i. Effect of Decision

Decisions to recognize omitted, additional, or increased costs incurred by any hospital; to adjust the hospital rates; or to otherwise award additional reimbursement to any hospital shall not result in any change in the peer group calculations for any rate component.

Rate adjustments granted under this provision shall be effective from the first day of the rate period to which the hospital's request for qualifying loss review relates, shall continue in effect during subsequent rate periods, and shall be inflated for subsequent years. However, no retroactive adjustment will be made to the rate or rates that were paid during any state fiscal year prior to the year for which qualifying loss review was requested.

j. Administrative Appeal

The hospital may appeal an adverse qualifying loss decision to the Office of the Secretary, Bureau of Appeals for the Department of Health and Hospitals, P.O. Box 4183, Baton Rouge, LA 70821-4183. The appeal must be lodged in writing with the Bureau of Appeals within thirty days of receipt of the written decision, and state the basis for the appeal. Rate notification date is considered to be five days from the date of the letter or the postmark date, whichever is later. The administrative appeal shall be conducted in accordance with the Louisiana Administrative Procedures Act (L.R.S.

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49:951 et seq). The Bureau of Appeals shall submit a recommended decision to the Secretary of the Department, who will issue the final decision.

k. Judicial Review

Judicial review of the Secretary's decision shall be in accordance with the Louisiana Administrative Procedures Act)L.R.S. 49:951 et seq) and shall be filed in the Nineteenth Judicial District Court.

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P.L.101-508,
Sections 4702-4703

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C. Out-of-State Facilities

For admissions on or after April 4, 1997, out-of-state facilities are reimbursed for inpatient hospital services provided to recipients under age twenty-one at seventy-two per cent (72%) of allowable billed charges. Out of state facilities will continue to be reimbursed for services provided to recipients age twenty-one and over at the lower of fifty per cent (50%) of allowable billed charges or the Medicaid per diem rate of the state wherein the services are provided. Allowable billed charges are the items and amounts listed on the claim form for medically necessary services provided to the recipient, which are consistent with charges billed to other payors for equivalent services.

D. Disproportionate Share Hospitals

Effective for inpatient hospital services provided on or after July 1, 1988, a payment adjustment for hospitals serving a disproportionate share of low income patients (DSH) shall be implemented in the following manner:

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1. Qualifying criteria for a Disproportionate Share Hospital:

   a. Hospital has at least two (2) obstetricians who have staff privileges and who have agreed to provide obstetric services to individuals who are Medicaid eligibles. In the case of a hospital located in a rural area (i.e., an area outside of a Metropolitan Statistical Area), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures; or

   b. Hospital treats inpatients who are predominantly individuals under 18 years of age; or

   c. Hospital which did not offer non-emergency obstetric services to the general population as of December 22, 1987; and

   d. Hospital has a utilization rate in excess of either of the below-specified minimum utilization rates:
      (i) Medicaid Utilization Rate - means a fraction (expressed as a percentage), the numerator of which is the hospital's number of Medicaid (Title XIX) inpatient days and the denominator of which is the total number of the hospital's inpatient days for a cost-reporting period.

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(i) Medicaid Utilization Rate (Continued)

Hospitals shall be deemed disproportionate share providers if their Medicaid utilization rates are in excess of the mean plus one standard deviation, of the Medicaid utilization rates for all hospitals in the state receiving payments; or

(ii) Low-income Utilization Rate - means the sum of:

(a) the fraction (expressed as a percentage), the numerator of which is the sum (for the period) of the total Medicaid patient revenues plus the amount of the cash subsidies for patient services received directly from State and local governments, and the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the cost reporting period; and

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(b) the fraction (expressed as a percentage), the numerator of which is the total amount of the hospital's charges for inpatient services which are attributable to charity (free) care in a period, less the portion of any cash subsidy as described in (ii) (a) above in the period which are reasonably attributable to inpatient hospital services; and the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the period. For public providers furnishing inpatient services free of charge or at a nominal charge, this percentage shall not be less than zero (0). The above numerator shall not include contractual allowances and discounts (other than for indigent patients ineligible for Medicaid), i.e., reductions in charges given to other third party payers, such as HMOs, Medicare, or blue Cross; nor charges attributable to Hill-Burton obligations.

A hospital providing "free care" must submit its criteria and procedures for identifying patients who qualify for free care to BHSF for approval. The policy for free care must be posted prominently and all patients must be advised of the availability of free care and procedures for applying.

Hospitals shall be deemed disproportionate share providers if their low-income utilization rates are in excess of twenty-five (25%) per cent.

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e. In addition to the qualification criteria outlined in Item 1.D.1.a-d. above, effective July 1, 1994, the qualifying disproportionate share hospital must also have a Medicaid inpatient utilization rate of at least one (1%) per cent.

2. Disproportionate Share Payment Adjustments - Dates of Service Prior to March 1, 1993

The higher of the below-specified payment adjustment factors shall be applied to the cost limits (per discharge and carve-out unit per diem) to determine allowable inpatient operating costs; and then to the total allowable Medicaid inpatient costs, for those hospitals qualifying as disproportionate share providers (DSH) as specified above in D.1.(a-d) for services provided on or after July 1, 1988, through February 28, 1993, and in accordance with Section 1923(c)(1-2) of the Act:

a. Medicaid Utilization Rate - a minimum payment of $1.00 plus a proportional adjustment equal to the percentage, or portion thereof, in excess of the mean plus one standard deviation;

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b. Low-income Utilization Rate - a minimum payment of $1.00 plus a proportional adjustment equal to the percentage, or portion thereof, of the low income utilization rate defined above in D.1.d., in excess of twenty-five per cent (25%) times the factor noted below:

(1) Effective for services July 1, 1988 and after - Excess times two;

(2) Effective for services November 1,1990 and after - Excess times three;

or

c. Medicare DSH rate - that percentage determined by the Medicare fiscal intermediary as a qualifying provider's disproportionate share adjustment factor for the purposes of Medicare reimbursement in accordance with rules established under Section 1886(d)(5)(F)(iv) and Section 1923(c)(1) of the Social Security Act.

Adjustment of the cost per discharge limitation and per diem limitations for carve out units (NICU /PICU/ Burn/ Transplant) shall be the product of the applicable limit and the appropriate disproportionate share adjustment factor. The adjusted cost limits shall be applied to determine allowable treatment operating costs, with "pass through" costs (capital, education, malpractice) added to these amounts to determine total allowable inpatient costs. The disproportionate share payment adjustment shall then be the product of the appropriate factor and the hospital's Medicaid total allowable inpatient costs.

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